

Performance Analysis of IMNCI in Madhya Pradesh



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Declaration

This study is resulted out of intensive efforts by of Vikas Samvad working for recognizing children's right to health, survival and nutrition across the State.

The views and analysis presented in the study is the responsibility is of VSS.

Preface

“Investment in child development can be viewed not only as a desirable societal investment for the nation’s future but also as fulfillment of the rights of every child to ‘survival, protection, and development’ so as to achieve their full potential. In this context, the challenges are to prevent the mortalities at birth and to secure the survival of every child without gender bias or any other social discrimination.

Growing up healthy is every child’s right and every parent’s dream for their children. And State claims to have made significant advances in improving child health and development over the past century by identifying the causes of many diseases; by developing preventive measures, treatments, and cures; and by improving the overall health status of our children. Still, Madhya Pradesh is having highest infant mortality rate (70) in the country. More shocking is the worst condition of tribal children for whom the under 5 mortality rate is 140 out of every 1000 live births.

The reality is that a society whose children are malnourished, abused, uneducated and exploited cannot claim to be making real progress, no matter how impressive the economic growth and per capita income levels might be. In fact, children in the State are experiencing major increases in chronic health conditions among children under 5 years of age especially Diarrhoea, Pneumonia, measles & other neo-natal problems (Asphyxia, Preterm, Sepsis etc). “The Lancet” establishes that the death chances due to diseases like diarrhea, measles and malaria for a malnourished child increases 9 to 18 folds as compared to a normal child.

Furthermore, the neonatal mortality contributes 45% of the total children mortality rate. It means that the death rate of children is highest in early neonatal periods (within 7 days of birth). It shows that to prevent or reduce child mortality rate the important thing is to control the mortality rate in early neonatal period.

Although a number of programs for fighting against the children health problems and prevention of child mortality have been chalked out but those programs didn’t prove their desirable impacts and sustainability to cure the problems and prevent its reoccurrence. It is mainly because the children are seen divided among the health and WCD departments. Whenever a child dies due to any unfavorable circumstances then instead of taking some curative steps the first thing seen is that both departments blame each other for the responsibility of not taking proper care of child health.

It was for the first time that a program named IMNCI was launched in which both the departments Health & WCD were involved. This program was initiated in Madhya

Pradesh during 2003 in Shivpuri district and then was replicated in 14 more districts till 2008. So, we undertook a study to analyze the implementation status and process of IMNCI program. In this study we tried to trace the extent of coordination between the staffs, the changes brought in roles and responsibilities among the AWW, ANM, Supervisors, Medical Officers and other concerned personnel. The changes brought in the perception of field staff and community with regard to childhood illnesses, home based care and early referral. As well as we tried to analyze that how far the program is effective in preventing child mortality due to preventable causes?

This study has been prepared by Vikas Samvad Samiti (VSS). VSS is very grateful to all NGOs, alliances and CSOs for their support in data collection and information from the field. The list of the organization that has helped us are Abhar Mahila Samiti (Chhatarpur), NIWCYD (Katni), Ekta Parishad (Katni) and TAAL (Dhar).

This study could not be possible without the generous support of ANM, AWW, ICDS Supervisors, LHV/Health Supervisors, CDPO, Medical Officers, IMNCI Coordinators, IMNCI Block Monitors, and other officers at Block, District and State levels of Health and WCD departments.

VSS would like to express its gratitude towards UNICEF for providing the technical support as and when needed for developing and designing the study.

VSS thanks our team namely; Sachin Kumar Jain, Smriti, Seema Jain, Raju Kumar, Prashant Dubey and Rolly Shivhare for putting immense hard work in giving final shape to this report. Special thanks to Manoj, Santosh and Sonu for providing necessary support.

Vikas Samvad

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ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Aaganwadi Center
AWW	Aaganwadi Worker
BMO	Block Medical Officer
CDPO	Child Development Project Officer
CHC	Community Health Center
DLHS	District Level Household Survey
ICDS	Integrated Child Development Services
IMNCI	Integrated Management of Neo-Natal & Childhood Illness
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
NFHS	National Family Health Survey
NRC	Nutritional Rehabilitation Center
NRHM	National Rural Health Mission
PHC	Primary Health Center
RCH	Reproductive Child Health
SHC	Sub-Health Center
SHG	Self Help Group
SNCU	Sick Newborn Care Unit
SNP	Supplementary Nutrition Programme
UNICEF	United Nations Children's Fund
VHSC	Village Health & Sanitation Committee
WCD	Women & Child Development
WHO	World Health Organisation

Executive Summary

In Madhya Pradesh the children under six years of age contributes 16 % to the total population of the State with total child population (0-6 years) of 10782214. There are some numbing statistics about children which show that ours is simply not "a world fit for children" – where their well-being and happiness is actually the most universally agreed aspiration we have.

The 4th and 5th goals of MDG also aim to resurrect the children health status all over the world. But still coming more than the half way across, the achievement status of MDG goals is not at all satisfactory in the Madhya Pradesh. According to NFHS-3 report 60.3 % children in our state are malnourished accounting for the highest number of malnourished children in country, 74.1 % children are suffering with anemia (any anemia), 5 % children are devoid of any vaccination and only 15.9 % children are breastfed within an hour of the birth. These data clearly indicates that the lives of our children are blighted by disadvantage and deprivation demanding our immediate attention and support, for the very foundations of development.

To take care of children's health the state government has implemented and launched many programs and IMNCI is one of those aiming to prevent neonatal & child mortality due to preventable diseases. IMNCI (Integrated Management of Neonatal and Childhood Illness) is a community intervention where the main emphasize is given to home based care of neonates and children and timely referral of sick ones in case of complications.

MDGs on Child Health

The Millennium Development Goals were formulated in 2000 & 8 set goals are to be achieved by 2015. MDG4 & MDG5 aims to reduce child mortality & to improve maternal health. Both these goals focus on reducing infant & child mortality due to childhood illness & other preventable causes. It is targeted to reduce IMR & U5MR to 27 & 41 respectively by the year 2015.

But the present status of infant mortality illustrates that Madhya Pradesh is unlikely to achieve the MDG targets of infant & child mortality. Infant death constitutes huge proportion of child mortality. M.P. stands at top position in infant mortality in the country with total IMR of 70 per 1000 live birth¹ and is reducing at a very slow pace from 99 in 1995 to 70/1000 in 2008.

Millions of newborns in the state die before their first birthday as they do not get basic care. To address this glaring gap, IMNCI program implementation started in Madhya Pradesh. Presently IMNCI is being implement in 15 districts in the state & all frontline health & nutrition workers(AWW & ANM) are trained for home based nutrition & health care of children under 5 years.

¹ Source : SRS 2008 released in Oct,2009

The IMNCI program at present is being implemented at 15 districts of the state and is contributing to control the complications in children causing any morbidity or mortality. A performance analysis based on case study analysis and observations of field situation was undertaken by VSS to learn the changes brought by IMNCI program and to compare the status of children health care practices. During the study we observed and analyzed following —

Training component— IMNCI is skill based training. The training under IMNCI is reported to be very beneficial by all the respondents but the lack is that there is no provision of follow up or refresher trainings especially for field staffs. While in non-IMNCI districts the skills and knowledge of field staffs is not as sound as that of IMNCI districts staffs on children health care and disease management.

Home based care— The home based care has been given special emphasis under IMNCI and is very effective strategy for disease management at an early stage. But the functional problem found in home based care is that the field staff is highly overloaded with a wide area and various activities including too much paper work. So it becomes practically impossible for field staffs to manage sufficient time to provide home based management and counseling to all the beneficiaries for children and maternal health care. In non-IMNCI districts the status of home visit is further in bad shape as compared to the IMNCI districts.

Referral— Under IMNCI the staff is oriented to identify and refer the sick children to public health institutes at earliest. But due to the lack of proper information among community about the childhood illness and services under IMNCI the community doesn't approach to the aaganwadi center for referral support. Also, the system and facilities at public health institutes are in so bad conditions that those who are reaching to the institutes by hard efforts of field staffs get so annoyed that they don't wish to visit again. Also AWW are mostly making oral referral & not ready to take-up the responsibility for child referral.

The instructions and the process regarding the incentive distribution are not at all clear. Due to these reason the referral process is hampered to a large extent. In non-IMNCI districts also the status of referral is very poor. Field staffs are not at all clear whether they have to refer sick children also or only to malnourished children.

Institutional facilities— The status of institutional facilities was found to be more or less same in both IMNCI and non-IMNCI districts. There is sever shortage of manpower & essential facilities for safe child birth, newborn care & treatment of childhood illness at block & district levels public health institutions. The most positive approach visible in

IMNCI district is the establishment of SNCU that leads to prevention of child mortality in newborn period. But block level institutions at IMNCI districts are still lacking such facilities.

Though in spite of being a very innovative program IMNCI is not meeting its objective of securing better child health and all these problems are due to the neglect or the neutral attitude of the administration. While in practical it is always seen that the lower most link i.e. the field staffs are often blamed for non-achievement of the set targets. Moreover, if someone complaints about the non-functioning of any program/activities or if any thing goes wrong then the foremost step taken is the removal/suspension of these field staffs who can do nothing to resurrect the things nor there is any support system available for them at district or state level which could help these field staffs to prevent the casualties.

To make IMNCI (or any program) really working and result orienting, the government should develop all the connected wings equally whether it is the training of implementing staffs, follow-up, supervision or the infrastructural support.

The present document presents the performance analysis of IMNCI at ground level and also presents a comparative analysis of the status and system regarding children health status in IMNCI (Guna & Katni) and non-IMNCI (Dhar & Chhatarpur) districts.

Profile of Madhya Pradesh

Madhya Pradesh lies in the center of the India and is surrounded by 5 states namely Uttar Pradesh, Chhattisgarh, Maharashtra, Gujarat and Rajasthan. It is the second largest state in terms of area.

Madhya Pradesh at a glance²

Demographic Profile

Area (in sq. kms.)	308,000
Districts	50
Tehasils	259
Development Blocks	313
Total villages	55,393
Populated villages	52,117
Gram Panchayats	23,040

Socio-economic Profile

Population (Census-2001)	60348023
Males	31443652
Females	28904371
Child population (0-6 years)	10782214
Decadal Growth (Census 2001) (%)	24.26
Sex Ratio (Females/1000 Males)	919
Density Of Population (Persons/ Square Km)	196
Urban Population %	26.67
Schedule Caste Population (In Million)	9.16
Schedule Tribe Population (In Million)	12.23
Population Below Poverty Line (%)	37.43
Literacy Rate (Census 2001) In %	63.7
Male Literate	19672274 (76.1%)
Female Literacy	11920289 (50.3 %)

² Source: Data obtained from Census 2001

Vital Health Indices

S. No.	Item	MP	India
1	Birth Rate (SRS 2008)	28	22.8
2	Death Rate (SRS 2008)	8.6	7.4
3	Total Fertility Rate (SRS 2006)	3.1	2.7
4	Infant Mortality Rate (SRS 2008)	70	53
5	Maternal Mortality Ratio (SRS 2001 - 2003)	379	301

Child & Maternal Health status in MP

The latest human development report of Madhya Pradesh clearly states that health status of Madhya Pradesh is far from satisfactory. State's performance on the infant mortality rate (IMR) and the maternal mortality rate (MMR), is far below than the national average. IMR is related to combination of factors including poor nutrition for their mothers while pregnant, inadequate immunization of mothers from tetanus and lack of hemoglobin in their bodies, poor sanitary and health care conditions at birth, poor care during and after deliveries, etc.

As per the latest 2005-2006 National Family Health Survey (NFHS-III) released recently by the Union Government, about 82.6 % children in age group of 6 to 35 months are anemic and 60 % children under three years of age are malnourished in Madhya Pradesh. Only 22.4% of the children aged 12-24 months are receiving immunization against all preventable diseases. As per the DLHS-3 report only 36.2% children in the state & in rural areas only 31.4% children are fully immunized against the government claim of 62.5% in 2007-08, & 63.6%¹ in 2008-09 children are fully immunized under child vaccination programme. DLHS-3 report further exposed the fact that 11.3% children from rural Madhya Pradesh & total 9.8% children through out the state have not at all received any vaccination.

Maternal death is an avoidable tragedy. No mother should die giving life. A little bit of care can go a long way in preventing this tragedy. However the analysis of the grass root reality and various reports shows that maternal health status is in grave condition in the State with only 47.1% institutional deliveries against the state government's claim of 79% in 2007-08. Madhya Pradesh accounts for 379 maternal deaths per 100000 live births and bags third position in maternal mortality rate in the nation. The percentage of pregnant women under the reproductive age 15-49 years who are anemic has increased from 49.9 % [NFHS II] to 57.9% [NFHS III].

Key Points of Maternal & Child Health from Madhya Pradesh³

- In M.P neonatal mortality rate is 44.9.
- Post neonatal mortality rate is 24.7 in M.P.
- In M.P infant mortality rate is 70 per 1000 live births⁴.
- M.P is second in Neonatal deaths when compared with BIMARU states.
- M.P is in Second position for Child mortality rate (under 5 mortality) recording 94.2.
- Malnourishment increased from 54% [NFHS-2] to 60 % [NFHS-3].
- M.P. records for the highest under 5 mortality rate among Tribal children 140.7 against the national U5 mortality rate of 95.7.
- M.P. ranks third in MMR with 379 maternal deaths per 100000 live births.
- In M.P. institutional deliveries for tribal women is only 8 %.

Madhya Pradesh counts for its highest contribution in Malnutrition and Infant Mortality in India as well as in the world. The most common causes of infant and child mortality in developing countries including India are perinatal conditions, acute respiratory infections, diarrhoea, malaria, measles and malnutrition. These are also the commonest causes of morbidity in young children. Neonatal mortality contributes to over 64% of infant deaths and most of these deaths occur during the first week of life. Mortality rate in the second month of life is also higher than at later ages. Any health program that aims at reducing Infant Mortality Rate needs to address mortality in the first two months of life, particularly in the first week of life.

³ National Family Health Survey (NFHS III), 2005-06

⁴ SRS 2008 released in 2009

Introduction to IMNCI

Bringing down Infant and Child Mortality Rates and improving Child Health & Survival has been an important goal of the Family Welfare Programs in India. The various child health programs were integrated in 1992 under the Child Survival and Safe Motherhood Programs and have continued to be a part of the Reproductive & Child Health Programme implemented since 1997.

Integrated Management of Neonatal & childhood illness (IMNCI) is a Child Health Intervention to be implemented as part of NRHM/RCH-II to bring down neonatal, infant & child mortality rate. During the mid-1990s, the World Health Organization (WHO), in collaboration with UNICEF and many other agencies, institutions and individuals, developed strategy known as the Integrated Management of Childhood Illness (IMCI). Although the major reason for developing the IMCI strategy stemmed from the needs of curative care, the strategy also addresses aspects of nutrition, immunization, and other important elements of disease prevention and health promotion. But since newborn care is an important issue for bringing down the infant mortality rate in India, this aspect has been included in the IMNCI package adapted by India. This strategy has been expanded in India to include all neonates and renamed as 'Integrated Management of Neonatal and Childhood Illness (IMNCI)'.

Implementation of IMNCI in the districts has to be seen as part of the Child Health Strategy under the National rural health mission/Reproductive and Child Health Programme- Phase II. It includes –

- Care of Newborns and Young Infants
- Promotion of Breastfeeding Practices/Counseling on feeding for all children below 2 years.
- Recognition of illness in newborn & childhood illness & management/referral
- Complete Immunization of all children under 5 years.
- Home visits in the postnatal period

The IMNCI clinical guidelines target children less than 5 years old — the age group that bears the highest burden of deaths from common childhood diseases

IMNCI districts in Madhya Pradesh⁵ – Under IMNCI package in Madhya Pradesh 12 district has been selected as IMNCI districts namely (1) Bhopal (2) Sehore (3) Vidisha (4) Morena (5) Datia (6) Bhind (7) Shivpuri (8) Guna (9) Ratlam (10) Jabalpur (11) Katni (12) Satna (13) Sheopur (14) Gwalior (15) Shahdol

⁵ Information obtained under RTI from Department of Public Health & Family Welfare in June'09

IMNCI & Its Component

a. Training

IMNCI is skill based training. The training is based on a participatory approach combining classroom sessions with hands-on clinical sessions in both facility and community settings.

Broadly, two categories of training are included, one for medical officers and a second for front-line functionaries including ANM's and Anganwadi Workers (AWW's). There are 2 types of trainings under IMNCI.

Training under IMNCI				
Type of Training	Personnel to be trained	Duration	Package to be used	Place of Training
Clinical skills training	Medical Officer and Pediatricians	8 days	Physicians Package	Medical college /District Hospital
	Health Workers, ANMs, LHV's, CDPO's, ICDS Supervisors and AWWs	8 days	Health Workers Package	District Hospital
Supervisory Skills Training	Medical Officers, Pediatricians, CDPO's LHV's)	2 days	Supervisory Skills package	Medical college /District Hospital

Follow-up Training (FUT)

The Follow-up Training is designed to improve supportive supervision skills such as methods for skill reinforcement, records review, and assessment of facility functioning. The intended participants include medical officers/pediatricians and health/ICDS supervisors who will be involved in supervisory, monitoring, and follow-up functions of IMNCI implementation. The duration of the training is 2 days

b. Home based Care

Home visits are an integral part of this intervention. Home visits by health workers (ANMs, AWWs, and link volunteers) help mothers and families to understand and provide essential newborn care at home and detect and manage newborns with special needs due to low birth weight or sickness. In addition the opportunity of home visit is to be used for the care of mothers during the post-partum period.

⁶ Operational guidelines of IMNCI taken from www.mohfw.nic.in

Three home visits are to be provided to every newborn starting with first visit on the day of birth (day 1) followed by visits on day 3 and day 7. For low birth weight babies, 3 more visits (total of six visits) are to be undertaken before the baby is one month of age.

c. Referral

Referral mechanism is designed to ensure that an identified sick infant or child can be swiftly transferred to a higher level of care when needed. Every health worker trained are made aware of where to refer a sick child and the staff at appropriate health facilities must be in position to identify and acknowledge the referral slips and give priority care to the sick children.

d. Institutional facilities & care

When the sick child is referred to health facility, the paramedical staff should attend them at priority & provide necessary treatment at the earliest. If the health facilities do not have required facility for treating sick newborn & childhood illness, it should refer the child immediately to higher level with better facilities.

IMNCI Package: IMNCI Package includes following interventions:

Care of Newborns and Young Infants (infants under 2 months)

- Keeping the child warm.
- Initiation of breastfeeding immediately after birth and counseling for exclusive breastfeeding and non-use of pre lacteal feeds.
- Cord, skin and eye care.
- Recognition of illness in newborn and management and/or referral).
- Immunization
- Home visits in the postnatal period.

Care of Infants (2 months to 5 years)

- Management of diarrhoea, acute respiratory infections (pneumonia) malaria, measles, acute ear infection, malnutrition and anemia.
- Recognition of illness and at risk conditions and management/referral)
- Prevention and management of Iron and Vitamin A deficiency.
- Counseling on feeding for all children below 2 years
- Counseling on feeding for malnourished children between 2 to 5 years.

About the Study

Need of the Study

IMNCI program is the only program of its kind with integrated approach for child health care. Under this program the two main departments taking care of child health viz. Department of Women & Child Development and Department of Public Health & Family Welfare are made to collaborate jointly for child health care. Community intervention through home based care is one of the main objectives of this program which is to be met by field staffs (ANM & AWW) of the departments.

IMNCI program started in M.P. in 2003 in Shivpuri district with the support of UNICEF and then later on other districts were included in different phases. Till 2009 18 districts have been selected for implementing IMNCI program. This study was taken to observe the changes brought by the program in the community practices on child care & in the roles & responsibilities of staff involved in the program implementation and their to observe the changes in the child health status.

Goal of Study

To study the neonatal & child health status in the light of the implementation process of IMNCI and compare the changes brought about by IMNCI program with non-IMNCI districts.

Objective of Study

- To observe the changes in status of neo-natal and child health due to IMNCI program.
- To observe the service delivery system of IMNCI program.
- To observe and analyze skills and care providing competencies of health care providers and other community level service providers in IMNCI & non-IMNCI districts.
- To study the situation of convergence among departments to implement IMNCI program.
- To study the role, limitations and support to the staff involved in the IMNCI
- To observe & compare sickness management practices at household, community level and health facility level in IMNCI & non-IMNCI districts.

Respondents for the Study

- ❖ IMNCI Coordinator
- ❖ Block Medical Officers
- ❖ Health Supervisors(LHV)
- ❖ Auxiliary Nurse Midwife (ANM)
- ❖ ICDS Program Coordinator
- ❖ ICDS Supervisors
- ❖ Anganwadi Workers
- ❖ Community Members/Beneficiaries family member

Sample Size

- ❖ District IMNCI Coordinator / District Health Officer
- ❖ One Medical Officer per block
- ❖ One LHV (Health Supervisor) per block
- ❖ CDPO of the block
- ❖ Two ICDS Supervisors per block
- ❖ Two ANM per block
- ❖ Three Aaganwadi workers per block

Area selected for study

To make a comparative analysis of the changes brought by IMNCI programs we have chosen IMNCI vs. non-IMNCI districts. For the purpose two IMNCI district namely Guna & Katni with two non-IMNCI district of Dhar & Chhatarpur were selected under the study. The study was conducted in two blocks of each district. One block was near the district head quarters and the other block was far from district head quarters. Following were the blocks selected for the study—

Guna	-	(1) Aron	and	(2) Bamori
Katni	-	(3) Badwara	and	(4) Vijayraghavgarh
Dhar	-	(5) Gandhwani	and	(6) Manawar
Chhatarpur	-	(7) Chhatarpur	and	(8) Rajnagar

Reasons for selecting the mentioned districts

The geography of Madhya Pradesh can be divided into different regions. Therefore, we have selected four districts from four different geographical regions of Madhya Pradesh viz. *Chambal, Bundelkhand, Baghelkhand and Malwa* region of the state.

- Guna is a district which has been chosen for IMNCI implementation in its very first phase in 2005 with special initiative of UNICEF. Guna is also a first district to establish Sick Newborn Care Unit (SNCU) in Dec 2007. Guna is located in the gwalior-chambal division.
- Katni is from Baghelkhand region of Madhya Pradesh & covering 23.7 % of tribal population. Katni has been selected for IMNCI implementation very recently in 2007 & training process is still undergoing in various blocks. So Katni has been selected for study to analyze the changes brought in the process of implementation through experience gained from other IMNCI district like Guna who have been implementing IMNCI program from last 3-4 years.
- Chhatarpur & Dhar are the two non-IMNCI districts selected for the study. Chhatarpur lies in Bundelkhand region of Madhya Pradesh. Feudalistic tendency is still over-powering the down trodden in Bundelkhand region & affective socio-economic & political life there. Also, Bundelkhand is facing the grave tragedy of drought continuously since last eight years & it had a severe impact on the maternal & child health status in the region. So to observe & analyze the initiative of the government to prevent childhood illness in district with special needs, chhatarpur has been selected.
- Dhar is the part of Malwa region & tribal constitutes more than 50 percent of the total population of the Dhar district. Still the infant mortality registration was zero for Dhar continuously for two years 2006-07 & 2007-2008 & then in 2008-09 death registration exceed to 739 in a day. Therefore to analyze the conditions of neonatal & childhood illness, Dhar is also undertaken for study.

Research Methodology

This study is a performance analysis of implementation process of IMNCI based on case study analysis, focused individual & group discussions and field observation from two IMNCI (Guna & Katni) & two non-IMNCI districts (Dhar & Chhatarpur) of Madhya Pradesh. Though this is not an in-depth research study of the status of IMNCI in Madhya Pradesh but it can be an authentic base for developing further research on IMNCI & for strategic planning for implementation & replication of IMNCI in other district in the State.

Data Collection: For data collection a team of three members from Vikas Samvad has been formed who were actively involved in research works on the issues of maternal & child health in Madhya Pradesh. The team visited the selected areas and interacted with the respondents. Following methods were adopted for data collection—

Schedule is a method of data collection containing set of questions that are being filled by the enumerators who are specially appointed & trained for this purpose.

Schedule of this study has been designed after discussion on the various components of IMNCI with some of the pediatrician, specialist doctors involved in IMNCI training & social workers actively work on the issues of child health in Madhya Pradesh.

Separate schedules were designed for field staff like Aaganwadi workers, ANM & supervision staff like ICDS supervisors, LHV, CDPO & Medical Officers. We have also designed a detailed schedule for community interaction with special focus on the parents of the sick newborn & child referred to health institution by service providers. One to one discussion with selected respondents was done and separate schedules were filled for each respondent.

Focus Group Discussion (FGD) is a qualitative method for data collection. FGD is a group discussion of approximately 6 - 12 persons guided by a facilitator, during which group members talk freely and spontaneously about a certain topic. Its purpose is to obtain in-depth information on concepts, perceptions and ideas of a group. In this study FGD has been conducted in the community to observe & understand the prospective of the community with regard to child health.

Case Study is qualitative method of data collection & involves careful and complete analysis of limited event or condition & its inter-relationship. In this study case studies from all the four selected districts has been collected during interaction with community & with field staff.

Observation methods have been developed with the objective of 'observing people in their natural setting - as they go about their everyday lives'. We have used observation method under the study to observe the community practices for neonatal & child care.

Data Analysis: After collecting primary data from the selected sample, it is tabulated in particular format designed for the study purpose. We have also collected and analyzed the available secondary data like reports of NFHS-3 & DLHS-3 on maternal & child health status in Madhya Pradesh. We have compared the status of children health care in IMNCI and non-IMNCI districts as well compared the health status with secondary data.

Principal Findings

- **Training of field staff**

Training is basic & foremost component of IMNCI program. This is for the first time a joint initiative of health & ICDS has been started to provide technical training to field staff like ANM & Anganwadi workers. Almost of the respondents under the survey accepted that the training is very beneficial as now they are better trained to understand & analyze the different aspects of child health in a more comprehensive manner. Now the trained AWWs & ANM have learned the technical knowledge on breastfeeding practices, giving medicine doses for minor ailments, counting pulses, identifying signs of childhood illness. Now they are aware as how, when & where to refer sick newborn & children to prevent any casualties.

Table:1-- IMNCI training and need of follow-up training

Respondent	Total no. of respondent	IMNCI Training beneficial or not		Need of Follow-up training		
		yes	no	yes	no	don't know
AWW	12	12	0	10	1	1
ANM	8	8	0	5	3	0

Byte of AWW⁷ - "Training se bahut janakari badi, ab hum baccho ki achhe se janch kar lete hai, jukam, pneumonia, bhukar jasi chhoti moti bimari ki janch bhi kar lete hai aur dawai ke naam bhi pata hai"

Even the field staff of non IMNCI district felt the need to have more comprehensive training on child health on proper breastfeeding practices, maternal & neonatal care, identifying complications/risk for sick children. At present the AWW of non-IMNCI districts are not technically trained to identify the complications in newborn children. They could only identify the underweight children that too not in a correct approach. The ANM of non-IMNCI districts are not oriented in the way as the ANM of IMNCI district to look after and take care of the new born children so there main focus is on immunization.

- **Need of Follow-up**

Though the training is very comprehensive & covering different aspects of neo-natal & child health care but around 83% of the AWWs & 62.5% of ANM feels the need of refresher training to fully elaborate their knowledge about neonatal & childhood care. The literacy level of most of the AWWs is very low & they many times forget the technical terms & processes, so need to refresher their knowledge at regular intervals.

⁷ Quote from the response of an AWW from vijayraghavgarh block of Katni district on 22 Aug'09

Even 75% ICDS supervisors of the total 8 ICDS supervisors interacted suggested that there should be follow-up training for AWW so that they could perform better. But unfortunately, IMNCI guidelines do not speak about follow-up training needs for lower grade field staff. It only includes follow-up supervision training for supervision staff.

One more lacuna found during the field study in IMNCI training was that there are no clear instructions on how to differentiate a sick child and a malnourished child. Due to this, the AWW and ANM are confused and consider malnourished children as sick children and pay attention only on referrals of malnourished children thus leaving the sick children.

- ***Service delivery to beneficiaries registered in AWC***

During the field study it was found that number of beneficiaries registered in AWC of all the four districts (IMNCI and non-IMNCI both) were very uneven. As per Supreme Court orders all the children below 6 years of age, all the adolescent girls and all the pregnant and lactating mothers must be registered in the Anganwadi center of the area but during the study we found that the mentioned order is not followed at all. If we take an average we found that nearly 105 children were registered on average in each Anganwadi ranging 65 to 210.

Box 1 ***Incomplete Registration in AWC***⁸

In Village of Guna district the total numbers of children found during survey of aanganwadi center were 201 covering all the children under 6 years of age. But the number of children registered in the AWC for the same period was merely 82. It indicates that either are their false entries in the survey or the remaining 59% children remain devoid of the services of AWC. Similar discrepancies were found in many other AWCs also.

Box 2 ***AWC behind the reach***⁹

The AWC of Nanhwara Sehja panchayat of Katni district has to cover even the 77 children of Bichpur tola, a village in Bhaganwara Panchayat. Bichpur tola is about 3 km from the AWC & so she visits that tola only once or twice a month. Due to long distance children from Bichpur also do not come to center.

Also the understanding of AWW regarding the number of beneficiaries to be registered on registering children is not clear, whether to register all the children surveyed or not. It was found that the total number of children surveyed in a village and the number of children registered in AWC were different. In some AWC all the children coming under a particular center were registered while in some centers it was not so. It was found that the number of pregnant and lactating women registered in all the Anganwadi centers studied found to be 10-15 irrespective of the total number of pregnant/lactating women in the area covered by an AWC. Though the Supreme Court Order of 2006 clearly instruct for universalization of

⁸ Information obtained from the records & response of AWW from Guna district on 9 Sep'09

⁹ Quoted during interaction with AWW on IMNCI on Aug'09

ICDS involving all adolescent girls under SNP. But as far as the number of adolescent girls is concerned it was found that AWC in the state are instructed for registering only 2 girls for providing supplementary nutrition at a given time period and there was a huge confusion among most of the AWW that whether the SNP is given to these girls or not. And it had a deep impact on the reproductive health of the adolescent girls & ultimately on the health of the newborn.

Another major hindrance observed during the field visit for non service delivery to the most vulnerable groups is wide prevalent caste stigma. During the community interaction at various villages, it was found that the Anganwadi Workers belonging to upper caste try to avoid visiting the lower caste beneficiaries and also don't allow their children in the centers. And contrary to these if aanganwadi worker belong to lower class, the upper caste communities neither send their children to AWCs nor allow the AWW to visit their homes for maternal & child health growth monitoring.

AWW never comes to us neither for home visits nor for providing any other information, we get information only if we visit AWC. She belongs to the upper caste and we poor & low caste people, why she would come, said Kashi Bai from a village in Katni.

One more problem noticed during the field visit was of the Anganwadi edifices (Anganwadi Bhawan). Most of the centers were not having their own edifices and were running on rental houses. The condition of these rental houses are very pity with very less space and no separate space for cooking or playing. The centers which are recently constructed are built outside the village mostly in roadsides and it is not possible for small children to reach the centers on their own.

According to one AWW¹¹, previously when the AWC was functional in the mid village large number of children used to come to the AWC but now the newly constructed AWC

Box 3 *Denial to Most Vulnerable*¹⁰

“Hamare Baccho Ko kabhi aaganwadi se kuch nahi milta” says Nermadiya Bai Ahirwar (Dai) of Harijan Mohalla.

Nearly 80 children of Harijan Mohalla in a village of Rajnagar block in Katni district are left out of any benefits of AWC due to wide spread caste stigma in the village.

Harijan Mohalla is dominated by schedule caste population mainly Ahirwar (40 households) and Basod (15 HH). AWW of this village belongs to the upper caste so she never visits the Harijan Mohalla nor do our children allowed in AWC says Jeevan Lal Basod.

¹⁰ Observed during FGD with the community on services of AWC in a village from Rajnagar block from Chhatarpur district on Sep-09

¹¹ Response of AWW on the question of poor attendance in AWC at Manawer Block of Dhar district

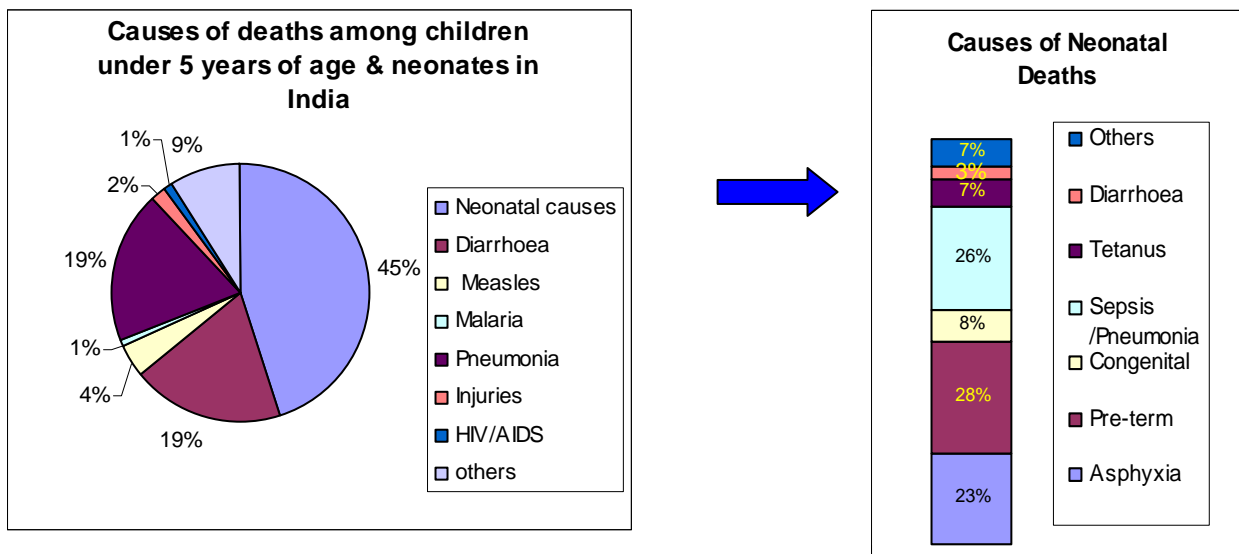
is located 2kms away from the village, so now only elder siblings or parents come to take up SNP.

The six AWC were found to be located outside the village around 2-3 kms from village center the among the 24 AWC visited during study & four of them were newly constructed. And four AWC visited still are functional in rented building.

The AWC of Khajura catering services to the population of 1310 in Vijayraghavgarh block is functional in Panchayat Bhawan and ration shop is also running there only. According to AWW¹² - **“Aaganwadi Bhawan nahi hai, Panchayat Bhawan mai aaganwadi lagti hai; bastise bahat dur hai aur yaha se bas nikati rahti hai isliye chhote bacche akela nahi aa pate hai, mujhe ya sahika ko hi unke ghar jana padta hai.”**

- *Common childhood diseases prevalent in villages*

Two million children die in India every year and over 60 percent of them die in the first 28 days of birth.¹³ More than 50% of these child deaths are attributed to diarrhea, pneumonia, acute respiratory illness, malaria or measles conditions that are either preventable or treatable with low cost interventions.¹⁴



Source: Mortality Country Fact sheet 2006, WHO

¹² Visited AWC during IMNCI study and interacted with AWW in Aug-09.

¹³ Report of International NGO, Save The Children ,2009

¹⁴ Diseases leading to deaths in children taken from ‘Accelerating Child Survival’ – Public Health Resource Network.

The common childhood diseases found to be almost similar in the both IMNCI and non-IMNCI districts.

The most common diseases found in the children is diarrhea due to change in seasons and prevailing unhygienic conditions. Other diseases found were fever with cold, malaria, cold and cough and other seasonal diseases. The health problem which were reported for neonates mainly are pneumonia, asphyxia, low birth weight and diarrhea Also the children seemed to be underweight & are in need of special nutritional care. But the major problem that was diagnosed that only children belonging to grade 3 & grade 4 were considered as malnourished while those under grade 1 & 2 were left unattended.

- ***Status of Child Immunization***

Immunization is a way of protecting the human body against infectious diseases through vaccination. Immunization prepares our body to fight against diseases in case we come into contact with them in the future. In spite of such a great need of immunization, its status in Madhya Pradesh is far behind the satisfaction. Recently released state report of DLHS III (in which total 4765 children were surveyed) reveals that only 36.2 % of children in the State are fully immunized while 9.8 % children were such which received no vaccine at all. In rural areas the status of immunization is more devastating where 11.3% children have received no immunization at all.

If we compare the immunization data of DLHS-3 with DLHS-2 data for selected district, we found that the percentage of fully immunized children has made more significant improvement in IMNCI district then non-IMNCI district. While in Guna & Katni, percentage of fully immunized children increased by 12% & 13% respectively. But in non IMNCI district, it had increased to slow pace of 7% & 1% respectively only for Dhar & Chhatarpur.

Table: 2 -- Status of Immunization in districts selected under study of M.P.¹⁵

District	Children Fully Immunized %	Children received BCG %	Children received DPT %	Children received 3 Polio doses %	Children received Measles Vaccine %	Children received Vitamin A supp. (9-35 month) %
M.P.	36.2	84.2	47.4	55.1	57.7	39.5
Guna	24	69.1	27.3	39.4	41.6	18.5
Katni	50.3	86.6	52.3	65.3	71.6	54.3
Dhar	39.0	78.6	50.8	61.5	54.5	30.1
Chhatarpur	30.1	80.1	31.8	52.1	53.6	27.8

¹⁵ Source: District Level House Survey(DLHS III) report 2007-08

But overall the immunization result is quite disappointing in IMNCI districts also. Out of the 15 districts undertaken as IMNCI districts only Bhopal & Sehore has above 60% full immunization. 11 districts are having less than 40% children fully immunized.

During the field visit also we found that the immunization status is not good in neither IMNCI districts nor in non-IMNCI districts. ANM visits the villages only on immunization day and give vaccines to children/women who arrives at the immunization spot and if someone is left due to any reason then the person have to either wait for next month or have to reach to ANM or nearest PHC on their own.

Box 4

Ground Realities of Immunization¹⁶

Preeti Burman, a pregnant lady (7 month) from a village in Barwara block had to go Barawara CHC by traveling 12 kms through cycle for get herself immunized with TT injection. Similarly, Rajkumari w/o Ghasita gave birth to malnourished and handicapped child in lack of proper ante-natal check-up & IFA tablets , as ANM rarely visits the village & even if she hardly stay their for one hour. Thus the children & pregnant ladies are not immunized timely.

On the contrary, according to ANMs, it is not that they want to avoid visiting villages on regular basis but some times they are unable to reach the planned village due to some unavoidable circumstances like it is difficult to cover distance villages with bad roads during heavy rains. And they cannot replan their visit to that village in the same month as they have very tight schedule & have to cover number of villages & even have to provide their services at the public health institutions to which they are attached with. The average number of villages covered by an AMN interviewed is 6.44 in the average range of 50 kms along with their reporting to SHC, PHC or CHC.

• ***Status of SNP***

The status of SNP was almost similar in IMNCI and non-IMNCI both the districts. Though a number of children were found undernourished but the quality and quantity of the supplementary food given in AWC was not satisfactory to meet the need. There is no proper storage facility for SNP in AWC due to which the SNP get spoiled/rotten, therefore community refused to accept SNP.

¹⁶ Information obtained through community interaction at a village in Badwara block on Aug'09

In some district under the new provision of SNP distribution, the budget for SNP comes in the account of Panchayat & SHG is deputed to prepare SNP for the AWCs. But most of the AWW & community complaint that SHGs do not prepare SNP regularly & in required quantity resulting in the reduction in the number of children coming to AWCs. It was told during the visit that in most of the centers the quantity of SNP (hot cooked meal) cooked is the same irrespective of the

Box 5

One Kg SNP for 150 beneficiaries

Aanganwadi Center of a village in Rajnagar block gets only one kilogram (1 kg) cooked meal irrespective of the number of beneficiaries. As per new system of SNP distribution, the funds are now being allocated to Panchayat & supplementary nutrition is cooked by the local self help group. The village has only one AWC covering the total population of 2038. The total number of children registered in AWC is 104 along with 19 pregnant women & 27 lactating mothers.

According to AWW, the quantity of SNP provided by SHG remains the same whether the beneficiaries present on the particular day is 40 or 80. As a result it is not possible to provide SNP to all the beneficiaries. As a result community now avoid coming to or sending there children in AWC.

SHG members say that they are getting budget only for providing limited quantity, so they can't help it. And Panchayat is not taking any actions even after repeated complaints.

attendance of the children in AWC and let alone the other beneficiaries of SNP this quantity is not enough even for the children registered in the center. As far the pregnant and lactating women and adolescent girls are concerned they are not at all getting any meal from Anganwadi centers neither cooked nor raw.

• ***Referral status & Referral incentives***

Health workers are implementing IMNCI, but assessments were frequently incomplete, and children requiring urgent referral were missed. Referral of sick child with complication is an essential component of IMNCI to prevent infant mortality. Even aanganwadi workers of non-IMNCI district are instructed to refer such children to the nearest public health institution as early as possible to prevent any causality in lack of medical care. However the most glaring fact regarding the status of child referral is that most of the AWWs are either not properly trained and motivated for referring the sick newborns & children or just making oral referral during community interaction. One of the reasons for poor referral is that ICDS is focusing more on the referral of malnourished children & thereby neglecting the sick

Table: 3 -- Mode of referral of sick children

District	Percentage of AWW Referring through Cards	Percentage of AWW advising Oral Referral	Percentage of No Referral
IMNCI	41.67	25	33.33
Non-IMNCI	16.67	16.67	66.66

child in need of immediate medical care.

*Byte of AWW*¹⁷—“*Pahle paisa milta tha to card banakar dete the per ab kewal asptal le jane ki salah de dete hai.*” (Previously I used to make referral through referral cards, when incentives were being distributed {till Mar’09} but now only suggest them to take the children to hospital as there is no provision for incentives now).

During the launch of IMNCI program in Madhya Pradesh, it was decided that an amount of Rs. 200 would be given to the parents of the referred child. However, the experience of ICDS & Health department staff in referral incentive distribution is something else. Most of them are not aware regarding the current norms of incentive distribution under

IMNCI. Even Block Medical Officers (BMO) & CDPO are not having clear guidelines for referral incentives

Table: 4 -- Information about incentive distribution for IMNCI

Type of field staff	Incentives Given (%)	Incentives not Given (%)	No Information (%)
AWW	8.33	33.33	58.34
ANM	25	25	50
ICDS Supervisor	0	62.5	37.5

Though norms were declared, but funds flow from state is not properly regulated and channelized to district & block levels to provide its benefits to the communities. In Guna, which

is known as the model IMNCI district of Madhya Pradesh, the referral incentives were provided to the beneficiaries only for the period of 3 months *viz* Jan-Mar’09¹⁹ while

IMNCI is implemented in Guna since 2007.

Box 6 *Souring Truth of Referral*¹⁸

Kusum, an aaganwadi worker of IMNCI district now do not make referrals through referral cards. “Previously, I have made 3-4 referrals through cards & parents of the sick child take them to CHC. But no attention has been paid to the referred cases by Doctors & other staffs & they also don’t get required medicines & injections from the hospital. And even no referral incentives were provided to the beneficiaries under IMNCI. So community insults me complaining for misguidance after returning form public hospitals. So now I do not refer the sick children under IMNCI” said Kusum.

In Katni, incentives were distributed for 2-3 months that too only through district hospital due to lack of sufficient fund flow from the state. CHC & PHC are not having required funds for referral incentives

distribution. The total number of referral reported under IMNCI for 0-2 months is 132 & total of number children (02-59 months) referred is 403. That means since inception of

¹⁷ Quoted from the response of AWW of IMNCI district, Guna about child referral in Sep’09

¹⁸ Analysis of information from the response of AWW to the question from interview schedule from IMNCI district

¹⁹ Information obtained from District Hospital, Guna during interaction with hospital administration in sep’09

IMNCI in Katni in Dec, 2007 the total number of children undertaken -for institutionalized medical care is only 535.

Also during the interaction with different medical officers & other paramedical staff, it was found that there is lack of effective communication with regards to the changed norms of referral incentives that came into effect since April'09. According to new norms now Rs. 100/- is to be provided as incentive support to referred children. While some are claiming that it will now be disbursed to Village Health & Sanitation Committee (VHSC) & others are informed that it will be under the jurisdiction of Rogi Kalyan Samiti.

The greatest hindrance to referral incentive is that though the norms have been changed but the field staff especially AWW & ANM who are more close to the community are not aware about new norms & thus are able to convey the community about the referral support.

An option that some officers at the district level tries to justify that in lack of funds for incentives, we manage it through the ambulance of the hospital to refer a sick newborn & children. But it is not valid justification because there is no separate transportation facility for the referral of sick children; it is clubbed with JSY vehicle. But the irony is that most of CHCs and District hospitals are having just a single or 2 JSY vehicle on road. And these 1 or 2 JSY is already covering large number of villages to bring pregnant women to the hospital for institutional deliveries. On an average, a CHC covering more than 100 villages are provided with single ambulance, similar is the condition at PHC level then how to imagine that a single JSY will cover all the pregnant women along with the transportation of sick children!!

In Guna also with special **Call Center** for JSY & IMNCI, mostly, vehicles are used only to fetch the beneficiaries of JSY, hardly some cases of child referral have been reported that too from CHC or PHC for referral of newborn with sever complications only. The call center started in September 2007 and since then total 13033 pregnant women referral cases under JSY are attended and the number of sick children referral is only 50 (till January 2009)²⁰.

Even some of the respondents accepted that it is not feasible to send ambulance to distance villages to bring a single sick child in lack of referral incentives, as poor villagers cannot afford to pay the transportation charges on their own.

In non-IMNCI districts, though there are also guidelines under RCH to monitor the progress of child health through home visits & thereby to promote early referral of sick

²⁰ Data obtained from District Hospital, Guna in Sep'09

child to immediate medical care. But in practical no such approach has been visible in an effective manner.

Moreover, in non-IMNCI districts the health officials and staffs view is that community is self responsible for the health care of their children and blames that poor health condition of children is due to negligence of parents and poor hygienic conditions. In non-IMNCI districts also (like in IMNCI district) focus is only on referring malnourished children due the continuous administrative pressures to curb malnutrition.

- ***Infant & Child Mortality***

India ranks 49th in under 5 mortality out of 189 countries²¹ and Madhya Pradesh is one of the state contributing for the highest number of infant and child mortality in the country. According to SRS 2008, infant mortality rate of M.P. is 70 per 1000 live births and the child mortality rate is 94.2 (NFHS- 3) recording the second highest data in children mortality. Neo-natal deaths contribute a huge proportion to Infant mortality rate. In M.P. neo-natal mortality rate is 44.9 which is quite higher then the national average of 39 deaths per 1000 live births.

To control these deaths a number of programs have been implemented in the state and IMNCI is one of those specially focusing on prevention of neo-natal and child mortalities. But if we see the ground picture the reality is different.

During the study we found that the status of birth registration is very poor in Anganwadi centers of IMNCI and non-IMNCI both the districts because the aaganwadi worker is not able to undergo regular visits either due to the lack of interest or many a times in lack of sufficient time, which hammers the timely referral of sick children.

Box 7 ***Sudden Alteration in Records***

The district of Dhar that reported zero deaths from April 2008 to January 2009 in government website suddenly shows 739 deaths at the end of February 2009, by giving an impression that all these 739 infants perished within a month. This amendment was made after the Hindustan times reported the underreporting of infant deaths by the department.

This definitely propel upon the Health department and women and child development department for not having proper accountable system that keep serious records of severe malnutrition children and child deaths in the state.

²¹ UNICEF-The state of the world's children-2009 report

Another reason for registration in rural & tribal villages is the continuous migration of

Table: 5-- No. of neonatal deaths in SNCU of Guna & Katni ²²

District	SNCU established in	Admissions in SNCU	No. of death in SNCU	Death Percentage	Data period (from--to)
Guna	Sept. 2007	2777	367	13.22	Dec'07 to June'09
Katni	Aug. 2009	157	18	11.46	Aug. '09 to Sept. '09

rural poor in search of livelihood. So while some times they are registered during pregnancy but their child birth/death remains unregistered. So while some times they are registered

during pregnancy but their child birth or death remains unregistered.

Another major problem is that in many regions aaganwadi workers are having information about registering only 10 pregnant women at a given time, thus leaving rest of pregnant women & as a result the children of unregistered pregnant women also remain unregistered. The figures of ANM and AWW for total number of children born or died in a village do not match each others. ANM only registered those pregnant women in their records who come for ANC check-up & immunization, leaving the rest behind.

Box - 8 *An Eye Opener*
In Madhya Pradesh the total population of children in age group 0-6 years is 10782214²³ and according to the Health Bulletin released by Public Health & Family Welfare Department for 2008-09, the number infants death reported for Madhya Pradesh is 28, 745. But, if we consider the infant mortality rate as per the SRS 2007 (which is 72/1000 live births) then the figure for total infants died in 2008-09 comes to be around 7,76,319.4 which is much higher than the reported figure (28, 745). Now, which data is to be taken as the right one for the total infant deaths is an un-answered question!!

- ***Community Practices – childhood illness / changes through initiatives of Health/ICDS***

During the study we tried to explore out the community practices for health care and their preferences of health institutes (private or government). We found that most of the rural peoples go to private practitioners or local quacks for the first line of treatment. Even according to the State specific report of NFHS 3 only 37.4 % people prefer government health

Table: 6—Community preferences for health institutes (As told by AWW).

District	Seek Govt health services	Percentage of Private Practitioners /local quacks
IMNCI	33.33	66.67
Non-IMNCI	48	52

²² Data obtained from SNCU progress report from District Hospital, Guna & Katni in Sep-Oct'09

²³ Administrative Report 2008-09, Department of Public Health & Family Welfare.

sector while 61.9 % prefer private health care services. The major reasons told by community behind preferring private health sector are the sadistic response of staffs at government institutes, lack of facilities and enough manpower at hospitals, distance of government institutes from villages and lack of transportation facilities.

Moreover if somehow rural people reach to government hospitals, they don't get any attention from doctors or nurses, they have to wait for hours for their turn and get no medicines from government hospitals. These all facts kill the trust of a man on government health institutes thus the rural people prefers local quacks or private health practitioners/institutes. Though they have to pay from their pocket and that too in a huge amount but still they go there due to their convenience.

Byte of some villager/AWW²⁴—paisa to sarkari asptal me bhi lagna hai aur private me bhi lekin private me doctor aur nurse bai kam se kam dhang se dekhte to hain.

We also found that some community are strongly superstitious and feels that the new born child should not be exposed to any outsider. So when AWW or ANM visit the newborn child they are not allowed to touch or even see the child thus AWW/ANM could not even know whether the child's health is satisfactory or not.

The rural community is not able to differentiate between malnourished and diseased children. They treat malnourished children as diseased one and take children to local quacks for first line treatment. Thus such children are more prone to deaths. Also people do not have any knowledge about the programs/facilities for children health care like NRC, IMNCI, and SNCU.

Box 9

Bengali Doctors do not Insult the Poor

“Bachhe Bimar hote hai to ab hum Bengali doctor ke paas le jate, pahle sarkari asptal jate the, per waha garibo ki koi sunwai nahi hoti”, said Anusuiya Bai of Banjari Village in Katni.

In the month of July 09, Anusuiya's daughter Minakshi (14months) was suffering from pneumonia. I took her to the AWW, she gave some medicine. But condition didn't improve till morning. Then AWW gave a card (referral card) & told to take her to CHC, Vijayraghvargarh. But at the hospital no Dr. was available at the moment & even nurse paid no attention rather she misbehaved on inquiring about doctor. I have to wait for two hours to see the doctor and at last I was told to purchase medicines from outside.

So now in case of any health problem we go to Bengali Doctors because it saves both our time & money. To reach CHC we need spent additional amount on transportation & wait for hours to visit the doctor. While Bengali Doctor is always available in the clinic and he do not insult us.

²⁴ Observed during discussion with the beneficiaries at AWC in Gandhwani block of Dhar

- ***Home visits –by AWW/ANM***

Home visits are the integral part of IMNCI, the field staff especially AWW & ANM are instructed to made regular home visits to monitor the progress of maternal & child health in their area. Aaganwadi worker have to give three to six home visits within seven days of child birth to orient the newly mother for essential newborn care and detect any sign of sickness or low birth weight.

But in practice, it was seen during field visit that it is only the AWW who gives some home visits but ANM & other field staff usually don't. In most of the cases, villagers informed that ANM only comes to the village for immunization at AWC or immunization site & usually never undergoes for home visits.

Another evident aspect is that home visits by AWW are not as per guidelines. The general trend of one or two home visits is visible in most of the AWW cases even in IMNCI districts. No special visits, as per rule, are undertaken for sick or low birth weight babies due to lack of time and heavy workload.

58.3 percent of AWW feels that the burden of their work has now increased with the implementation of IMNCI program. Few AWW

<i>Table: 7 – Status of home visits</i>				
District	Field Staff	One or two visit (%)	As per the norms (%)	As required (%)
IMNCI	AWW	33.33	16.67	50
	ANM	50	25	25
Non-IMNCI	AWW	58.33	16.67	25
	ANM	62.5	25	12.5

acknowledged that they usually meet beneficiaries while passing through in the village & due to that they are unable to fill the required formats for home visits but they are well conversant with the conditions.

In non-IMNCI districts status of home visit is further poor. They do not make home visit as a process to be undertaken on regular basis. They usually meet the beneficiaries whenever they come to AWC to take SNP or for immunization. They by and large carry out home visit whenever called or if there is some emergency.

- ***Supervision of IMNCI implementation***

Supervision is very imperative component to assure the success of any program. The process of IMNCI cannot be understood in holistic framework without appraising the element of effective supervision. For undertaking the effective monitoring & supervision, a district IMNCI coordinator has been appointed at district level & at block level BMOs, LHVs & ICDS supervisors are trained to provide supervision support. Though

coordinative approach has been adapted for supervision & monitoring but there were noticeable hurdles which were commonly visible at field level implementation process.

Firstly, there is one District Coordinator who is in-charge for overall monitoring of IMNCI program in the district. The district Coordinator has to arrange & facilitate trainings (for AWWs, ANM, Supervisors, medical officers of the district), Coordinate with ICDS & Health department at district and block level & undertakes supervisory field visits. IMNCI coordinators have to deal with state for required budget and other requirements also. So with all these loads it is genuinely not possible for one person to monitor the activity with needed intension and seriousness.

ICDS supervisors & LHV accepted during the interviews that they are already too much overloaded so don't have time to pay required attention towards IMNCI supervision. As far as BMOs are concerned so it was found during the study that there were either one or two MOs posted at CHC/PHC and he/she have to look after administrative, medical (OPD or any emergency) and all other related responsibilities of the CHC/PHC so it is not possible for them to go for supervision in fields.

Thus there is nobody who is responsible for overall implementation of IMNCI at the block level. In this matter, UNICEF has made a very innovative step at Guna & Shivpuri by appointing **Block Monitors**. These Block Monitors are not only providing supervisory support but also helps field works to understand the process IMNCI in holistic manner. They also assist to bring better coordination between ICDS & Health Department in the block thus forming a linkage bridge between the two departments. This approach should be adopted in all the IMNCI districts so that impact of IMNCI program can be measured accurately through effective implementation.

Another point to be noticed under IMNCI, special formats are designed for supervision purpose. But these supervision formats are too complicated and lengthy (time consuming). Supervisors notify that it takes around 3 to 4 hours to fill just a one form covering a single AWC & only 50/- per format is given as incentives. It is very difficult for them to spend that much time along with completing other reporting formats for ICDS.

Even the area of supervision is very wide. Each supervisor on an average has to cover nearly 25 AWC in an area of around 50-60kms. Often supervisors have to walk miles to reach distant remote villages as no transportation facilities are available there.

Another lacuna in the supervision of IMNCI is that there is no provision for organizing separate meeting for IMNCI monitoring. It is handled with WCD's monthly meeting, so

the specific problems faced by AWWs in IMNCI implementation remained untouched & unsolved.

- ***Infrastructure for newborn care – at AWC & at health centers***

Although the aaganwadi workers are provided with skilled training under IMNCI to monitor the growth of newborn & mother & to identify any sign of complications at the earliest; but it is regrettable that they are not supplied with necessary support for these works. Most of the AWC even lack proper weight machines to measure the weights of newborn babies, pregnant women & lactating mothers or even if it is their, they are not in working conditions. Among the 12 aaganwadi workers interviewed in IMNCI district 11 of them responded to the non availability of weight machines with tray for measuring

weights of infants & newborn & in one center which is having infant weight machine was not found in working condition. Similarly, 58.3% & 25% AWC in IMNCI district in comparison to 75% & 16.6% of AWC in non-IMNCI district are in lack of weight machines of

AWC	Weight Machines for Adult		Weight Machines for Children		Weight Machines for New born	
	available	not available	available	not available	available	not available
IMNCI - District	5	7	9	3	1	11
Non-IMNCI District	3	9	10	2	0	12
Total percentage (24 AWC)	33.33	66.67	79.17	20.83	4.17	95.83

adult & children respectively. Thus the condition of infrastructural support to AWC of IMNCI district is no better than non-IMNCI district. AWW stated that they are either not having weight machines for infants & adult or are in bad shape. Similarly none of the AWW is provided with thermometer to measure temperature of children for early identification of fever.

Box 10

Affirmative Actions

In Guna a new intervention has been done to control the neo-natal mortality. Under this intervention new born corners have been established at some selected PHC & CHC levels as first level of SNCU to monitor health progress of sick child. It is planned to replicate this intervention in all the CHC & PHC of the district. Also a newborn corner is established in every delivery centers of the district where incubators/warmers are kept and training is imparted to the nurse for the special care of the newborn child. Such initiatives are required in each & every health institutions of the state.

The neonatal period carries highest probability for infant mortality. But on the other hand, the major problem commonly reported by the respondents of health departments that public health institutions still are facing severe shortage of facilities for newborn & child care. Primary/ Community Health Centers at which sick child is referred for first line of treatment do not possess sufficient facilities for newborn care. CHC, the biggest public institution at the block level in most places have either one or two incubators/warmers and other infrastructural support. Even they are not provided with separate transportation facilities for child referral to high grade services.

According to Dr. R.K. Naiyar at SNCU Guna "In this SNCU we are getting babies from Guna, Ashok Nagar, Shivpuri as well as those born here. 90 percent of these have severe complications. With the technology and the expertise we have here, around 85 percent of the babies are able to survive."

In IMNCI districts, a special initiative the Sick Newborn Care Unit (SNCU) is being established to prevent neonatal mortalities. But it is not established in all the IMNCI district so far. Another problem is that due to very high cost of establishing SNCU, they are established only at the district level, therefore it not accessible to the communities residing in remote villages with lack of public transportation.

- ***Status of essential drug supply for treatment of childhood illness***

Regular supply of essential drugs for treatment is an area of big concern in public health institutions of the state. In such a circumstance thinking for the smooth supply of drugs for the treatment of childhood illness is big delusion. The supply of medicines to district is regulated by & large at the state levels. Medicines are purchased in bulk at the state level and are distributed to districts and from district to block level irrespective of the needs & demands of a particular area.

Table: 9- Medicine supply

District	Health Staff	Regular Supply (%)	Irregular Supply (%)	As per supply from higher levels- district/state (%)
IMNCI	MO	50	0	50
	LHV	50	25	25
Non-IMNCI	MO	25	0	75
	LHV	25	25	50

62.5 % of the respondents at supervision level from the health institutions complaint that there is often & on irregularity in the supply of essential drugs like ORS, mebendazole, IFA, etc needed to secure good maternal & child health.

Box 11***Untold Misery of Health Institutions***²⁵

One of the Medical Officer at the block told that CHC is supplied with some of the costly drugs that are used for surgeries purpose like pam, ketamine etc that is not at all useful at CHC level. "I had made constant reminder at the district hospital to take back these drugs, but no efforts has been taken & the medicines are about to expire. On the contrary I had made repeated request for permission since last one year to purchase 100 mucus abstractors that are very essential for safe child birth and hardly costs Rs. 25/-per abstractor, but still not supplied or permitted to purchase. And even the CHC is not supplied with most basic medicines like Paracetamol since last 3 months.

Similarly, Aaganwadi centers which are considered as the first center to provide life saving drugs to the village community before accessing higher grade health services, is not supplied with medicines since last three years. Previously, ICDS used to provide medicine kit to the AWCs at regular intervals but for the past 3 years this supply was hindered. Due to such large gap, the trust of community on AWCs had diminished. Then an alternative arrangement at local level has been made in which ANM use to supply some essential drugs to AWCs. But it cannot continue long as norms had been further changed and now ASHA worker became the depot holder in the village to keep life saving drugs. In such a condition lack of medicines supply to AWC leads to big gaps as now community do not approach AWW in case their children got sick & thus AWW remains ignorant about the situations.

But recently, process of supply of 'Medicine Kit' to AWC has been restarted, that shows positive indications for child health, if it continues at regular intervals.

²⁵ Response of Block Medical Officer on the question of medicine supply at block level during field visit for IMNCI study in sep'09

Problems faced by field staff

i. In IMNCI Districts

Though the problems have been mentioned above (under different heads) but still the major problems faced by field staff in implementing IMNCI program are as under—

- ***In case of any problems regarding IMNCI AWW don't know whom to approach for guidance—*** Whenever AWW face any problem they ask their supervisors (ICDS supervisors) for appropriate solutions but ICDS supervisors are unable to sort either due to lack of information or due to lack of time. ICDS supervisors advise AWW to ask the Health supervisor in case of any problem in IMNCI and the Health supervisors are not always there to solve the queries or cannot interact with AWW due to heavy workload. In such conditions AWW either leave the formats unfilled or fill the incorrect informations.
- ***AWW have to manage a number of tasks and children in AWC—***An AWW is responsible to provide all the 6 services under ICDS viz. imparting pre-school education, feeding supplementary nutrition, Growth monitoring of children, basic health care and referral services, nutrition and health counseling and immunization. Along with these activities the AWW have to manage the small children coming to AWC and in case Helper is not appointed/absent she have to distribute the nutrition food also. In addition they have to go for home visits, village survey and have to fill the 14 different formats/registers. The have to attend the sector meetings also. And simultaneously AWW have to implement the IMNCI program and have to fill its formats. Now how is it possible for one person to handle all these tasks at a time!!
- ***Like AWW, ANM are also overloaded*** with monitoring, survey, immunization etc. activities of 3-15 villages on an average. Then they have to provide services in the SHC/PHC/CHC they are attached with.
- ***Wide Field Area—*** The field Supervisors needs to cover distance villages in an average area of approximately 50-60 kms. The transportation norms are very nominal & often remote villages are having limited or no transportation facilities. Therefore the field Supervisors need to walk miles to reach AWC & are able to cover only one or maximum two AWC in a day. Thus due to wider supervision area, effective supervision is hampered.
- ***Format filling more technical and tough—***Formats given to AWW, ANM, Supervisors are too much technical and lengthy. Each form of supervisor consumes 2 to

3 hours for filling and it is usually not possible for supervisors to spend that much of time just for one form. The literacy level of AWW is very low; some AWW are literate upto 5th standard only and in such conditions they are not able to fill the forms of IMNCI with accuracy.

- ***Salary/Remuneration of AWW not enough and is not released regular***— During the visit most of the AWW complained about irregular release of payments. There is no separate incentive given for the works done under IMNCI program.

ii. In Non-IMNCI districts

- ***Lack of proper infrastructural supports in AWC***— It was found that most of the Anganwadi centers lack their own edifices. The availability of utensils, playing kits and pre-school education materials are not sufficient. Supply of medicine kit is also hindered for the past 3 years.
- ***Lack of technical knowledge***—The AWW of non-IMNCI districts have not received any special training on children health care and if let alone the special training most of the AWW have yet not received the basic training under ICDS program in the state. Due to lack of training the AWW are not able to identify and council for the sick neonates and children.
- ***Overloaded with paper works***—The AWW of non-IMNCI districts also reported of the overburden of paper works. They have to update 14 formats of ICDS along with looking after all the other services to be provided through AWC.
- ***The AWW of non-IMNCI district are not that much inclined about the need of home visits*** and the importance of counseling for maternal and children health care. Most of the AWW don't actually go for home visits but they use to interact with the beneficiary or their relatives whenever or wherever they meet in the village.
- ***Overpopulated AWC***— In most of the villages still there is one AWC to take care of all the children (0-6 years), pregnant and lactating mothers. Though the orders for opening more AWC/mini-AWC have been released by State but it will still take time to be implemented at fields. So it becomes difficult for AWW to manage all the children and other beneficiaries of the area.

Suggestions for successful implementation of IMNCI by personnel's implementing IMNCI

During the study we asked the respondents about the problems in the present system of IMNCI program implementation and the suggestions to make the system more functional and result orienting at grassroot level. The problems and suggestions mentioned by respondents were more or less common. The problems are already detailed above and the suggestions are as follows—

Suggestions given by AWW —

- Regular Refresher/follow-up training for field staffs.
- Complete and regular supply of essential medicines like antibiotics, fever, boils, diarrhoea etc. to AWCs.
- Incentives must be given to the children and their parents under IMNCI program.
- AWCs should be supplied with separate weight machines for infant, children and adults. Also thermometers must be made available. AWC must be supplied with sufficient educational charts, playing kits and medicine kits. Utensils and Mats must be re-supplied at periodic intervals.
- Ambulance facility for referral of sick children.
- AWC should have its own building and must be constructed in the middle of the village so that it could be in the reach of the children and community easily.
- Quality of SNP must be improved and its supply must be regular and in sufficient quantity.

Box-12 *Due Respect to Aaganwadi Workers*²⁶

AWW is an important link for health & nutrition care services to marginalized communities especially in rural areas. They provides pre-school education to children under 6 years, counsel pregnant & lactating women regarding maternal & child health care, monitor maternal & child health progress & refer them to health institutions in case of any sign of complications. All these works needs technical competence. But it is very regrettable that they are considered to be unskilled worker even by the officials of Health & WCD departments and treated roughly. Then how we can expect the community to give respect to these workers!!!!!!!!!!!!

Thus it is very imperative that work of AWW must be acknowledged & should be given due respect.

²⁶ Observed & analyzed from the responses obtained during the interactions with AWW & ICDS supervisors.

- ANM must visit village regularly.
- Regular refresher & follow-up training to AWW for children and maternal cares along with primary first aid care in non-IMNCI districts also.
- AWW honorarium must be released at time and there must be some incentives given to field staffs for IMNCI.
- There must be 2 AWW in one AWC to look after children.
- Maintenance fund for AWC must be again started and Stationery must also be made available to AWW.

Suggestions given by ANM —

- Field area of ANMs should be squeezed so that they can take undertake effective monitoring of maternal & child health & can provide required services.
- Regular supply of essential drugs as per the needs.
- Refresher trainings at regular intervals to update the knowledge & skills of ANMs.
- Ambulance facilities should be developed for referrals under IMNCI.
- Incentives must be given for the referral of sick children under IMNCI.
- Joint sector meeting of Health & WCD departments should be conducted regularly to establish better coordination between ANMs & AWWs.
- AWWs should be trained effectively to properly fill the formats under IMNCI.
- Proper & timely attention by doctors at health institutions to the beneficiaries referred under IMNCI.
- Good workers should be awarded.
- Like AWWs, the ANM should also be given some support staff to visit distant & remote villages.
- Health facilities at block level health institutions must be developed.
- Monitoring system under IMNCI should be made more effective.

Suggestions given by Supervisors —

- Practical demonstrations of child health care practices, format filling techniques and counseling skills to field staff must be given.
- Regular follow-up trainings must be organised for field staffs also.
- Separate meetings for IMNCI program supervision must be held and this meeting should be a joint sector meeting involving staffs of health and WCD department.
- Reporting formats of IMNCI should be simplified.
- Incentives must be given to the children and their parents under IMNCI program.
- A supportive person must be appointed to help the supervisors to carry their work more efficiently.
- ASHA workers must also be trained for IMNCI program implementation.
- Awareness camps at village levels must be organized to disseminate proper information about IMNCI and other programs for child and maternal health care.
- Transportation facilities for sick children referral must be made available.
- AWC should be provided with proper and sufficient infrastructural supports.
- Good workers (field staff) must be promoted and applauded.
- Stationery must be regularly provided to supervisors as well as field staff and some fund must be given for maintenance of AWC.
- Supervisors should not be involved in other works of village panchayats.
- AWW should be considered an important link for child health care and must be treated with dignity by all the officials visiting the village.
- SNP procurement and distribution should be under the control of AWC rather the Panchayat.
- Better health care facilities must be maintained at first referral units and the medical staffs must treat the community with sensitivity.
- Field staff should not be overloaded with paper works otherwise they don't have enough time to interact with the community.

Conclusion/Significance of IMNCI

Madhya Pradesh today has become a synonym for malnutrition with 60.3% malnourished children in the state. And to counter the nuance of malnutrition and its consequences on children health special initiatives like IMNCI must be promoted at priority level. This program is the only one of its kind addressing the need of neo-natal and children health care in an integrated approach. During the field visit we found that the IMNCI program is very much appreciated by the field staffs (ANM/AWW) and supervisors mainly because of its technical training component.

Every coin has two faces and likewise the IMNCI program also. There are some gaps in this program but the main thing is that there are many positive points in this initiative. Here we are mentioning the major positive significances of IMNCI program as per field experiences. We found that these positive approaches are the outcomes of the learning by doing process. And these approaches must be appreciated and should be considered while planning for the implementation of IMNCI in other districts—

- **Joint Venture of Health & ICDS**— IMNCI is very innovative approach to implement a program of child health care with the joint efforts of two departments *viz.* WCD & Health department. In IMNCI districts, the staff of the two departments go hand in hand for integrated management of childhood illness while such collaborative approach found missing in non-IMNCI districts.
- **Training and home based care**— Field staffs in IMNCI are provided special technical training for 8 days in child health care, it helps in boosting their knowledge & skills for better home based care for maternal & newborn health. Now they are able to identify childhood illness at an early stage which reduces the chance of child mortality due to preventable causes. But in non-IMNCI district the AWW & other field staff are not given any such training by Health department & thus lack skills for better home based care for newborn & children.
- **Provision of special monitoring staff to manage Childhood illness** — In IMNCI district an integrated approach to prevent & cure all sorts of newborn & childhood illness has been adopted. For this an IMNCI coordinators has been appointed by Health Department to look after the overall child health progress in the district.

These coordinators are very young & energetic & dedicated for bringing positive changes in the status of child health in their districts. These coordinators act as link between WCD & Health department. And In Guna district even Block monitors are also being appointed with the initiative of UNICEF to monitor the implementation of

IMNCI program in the block. But non IMNCI districts lack such integrated approach & in these districts the children are divided into sections/ departments as per their age & illness.

- **SNCU/new born corners**—Sick newborn care units/corners are established in IMNCI districts with the support of UNICEF to prevent mortalities in most death prone period i.e. the neonatal period. But in non-IMNCI, no special facilities are meant or established to monitor the health problems in neonatal period

- **Immediate medical care for newborn & sick children**—Again in IMNCI district the staff are trained to identify the childhood illness & refer them in care of any emergency at the earliest. This helps to prevent & reduce any causality due to preventable causes. But in non-IMNCI district though the staff is instructed to refer sick child but not trained to identify the sickness. So they usually do not refer the sick children.

- **More focus on home based care**— Home is the first unit to take care of any illness and under IMNCI program the home based care is one of the major components to arrest childhood illness at earliest. In IMNCI training the Anganwadi workers & ANM are oriented with right practices for home based care like proper breastfeeding, keeping newborn child warm & proper hygiene practices etc. They counsel the mothers & other family members with Dos & Don't of newborn care. Such effective home based care are rarely visible in non-IMNCI districts.

Box 13

A step towards Success²⁷

Kareena of Village Jugiakab age 8 months was brought by the AWW in district hospital, Katni complaining of blood in stools. The AWW assessed the child as per the instructions given in the IMNCI training and classified her as Dysentery with Severe Dehydration. AWW immediately filled up the referral card and counseled the parents to take the child to the District Hospital at Katni.

At District Hospital the girl was admitted and treated. Rs. 200 paid at the time of discharge Thus the life of Kareena was saved because AWW was technically trained on identifying the illness of the child. This shows that the technical knowledge and referral process instructed in IMNCI is an effective strategy to control childhood illness/complications.

²⁷ Case study obtained from IMNCI Coordinator, District Hospital, Katni in Oct'09

Suggestive Measures

IMNCI strategy has emerged as a promising approach to deal with issues related to child survival in a more holistic manner. But to make it more feasible & effective strategy, we like to recommend following suggestions based on the field experiences of the study—

- **Follow-up trainings**— According to IMNCI guidelines the component of follow-up trainings is kept only for supervision staffs while there is an immense need of follow-up trainings/refresher courses for the field staffs. We recommend this because the refresher training will help the field staff to revise and update their knowledge and skills on children health care. The refresher training will further help in recognizing the lacks and minimizing the mistakes done in implementing IMNCI at field level. Also it will help the less educated field staffs to remember how to fill the formats and the better counseling practices for home based care.
- **Referral incentive to parents/children**—In IMNCI guidelines previously there was a clause of providing an incentive of Rs. 200/- to the parents of sick children referred under IMNCI but this clause has been changed since April 2009 according to which now incentive of Rs. 100/- is to be given by VHSC. The agony is that there is no clear information about incentive distribution among the working staffs. Even the VHSC committee is not aware of this new guideline. We recommend that there should be clear cut guidelines about the process of incentive distribution and should be disseminated to each and every working staff. Simultaneously, the amount of referral incentive should also be increased so that it could help in covering at least the transportation cost beared by the community.
- **Supervision staff (Block Monitors, IMNCI)**—Supervision is the backbone of any program to implement it effectively and for an effective supervision there must be enough staff & supervision area must be narrowed . As in Guna district, the provision of Block coordinators must also be replicated in other districts as it helps in proper monitoring and supervision of the program.
- **Formats simplification**— During the study we found that the formats to be filled under IMNCI programs are much technical and lengthy. And all the staff members whether it is field staff or the supervision staff reported that they feel difficulty in filling the formats. Due to this formats either remain unfilled or false data are filled. So we recommend that the formats should be made simplified and less time consuming.
- **Record maintenance**— It was seen during the study that record maintenance regarding the referral of sick children under IMNCI is very poor. Records for those children who

are referred without referral cards or parents coming directly are not at all covered in reporting system neither at village level nor at the district level. Even the data of malnourished children referred to NRC under IMNCI are not accurately recorded.

- **Sensitizing health staff**— It has also been noticed that no priorities are being given to the children referred under IMNCI. Health staff shows insensitive attitude even towards small kids. The small children are very fragile & cannot wait longer for getting treatment.
- **Improving infrastructural status of AWC & Health institutes** — Anganwadi center are the first unit of primary health services available within the village. But it very sad that they lacks basic infrastructural support- no Anganwadi building, no medicine supply, insufficient supply of educational & playing materials, utensils, no proper supply of qualitative SNP, etc & need immediate attention & improvements.

Similarly, the conditions of public health institutions are no better. Most of the healths institutions at block level (CHC/PHC) are facing sever shortage of manpower, no proper facilities for safe deliveries & to cure childhood illness

- **Joint sector meetings**—Successful implementation of IMNCI need to be supported with the joint sector meeting of Health & WCD department .Joint sector meeting would being real coordination between the field staff of two departments & will smoothen the process of IMNCI implementation.
- **Replication of IMNCI in other districts**—We would like to recommend that the initiative of IMNCI should be replicated in all the remaining districts of the state or some integrated approach should be opted for neonatal and child health care in an holistic manner. Under this approach the staffs of health and WCD departments must be trained with technical skills to take home based care of maternal and child health care.